STATE OF NEW YORK
DEPARTMENT OF HEALTH
Riverview Center 150 Broadway Albany, New York 12204-2719

February 13, 2007

Rabbi Zarchi
Keren Peulos
440 Albany Avenue
Brooklyn, NY 11213

CACFP Agreement Number: 5422

Dear Ms. Zarchi:

This package follows your recent telephone call to the New York State Department of Health, Child and Adult Care Food Program (CACFP) requesting an application for participation. It appears that your organization may be eligible for the program.

CACFP has estimated that your yearly reimbursement could be $30,000.00. This is based on the number of children currently attending your center(s) and the types of meals that you are serving. Your actual reimbursement will be different than this amount.

Enclosed are the required application forms. Some of the following forms have been partially completed with information provided over the phone. Complete these forms, correcting them as necessary. Make certain that all of the forms listed below are completed and returned to CACFP.

DOH – 3840 Agreement between the State and Sponsoring Organizations of Centers

DOH – 3671 Certificate of Authority

DOH – 3706 Application for Participation and Management Plan

DOH – 3682 Application for Participation of Individual Child Day Care Centers

DOH – 4217 Listing of Board of Directors Members

CACFP-110 – Menu Planning Form-Child

In addition to the requested forms, please send the documents listed below:

- Documentation from the Internal Revenue Service (IRS) that includes the Federal Employer Identification Number (FEIN) assigned to your organization.

- A copy of your organization's most recent IRS Form #990 filing to the Internal Revenue Service (IRS) *or* your organization's annual budget.
- A copy of correspondence from the Internal Revenue Service (IRS) that documents your organization's non-profit income tax exempt status (generally a 501(c)(3).
- A copy of correspondence from NYS Office of the Attorney General Charities Bureau that provides your organization's NYS Charity Registration Number *or* states that your organization is exempt from registration.
- A copy of the current day care license or school age child care registration.

Enclosed is a CACFP income eligibility application (DOH – 3688) and a Letter to Households (DOH – 3673). These forms are available in English or in Spanish. You must provide these two documents to the parent or guardian of each enrolled child. When the applications are complete and returned to you, use the enclosed CACFP Income Eligibility Guidelines (DOH – 3687) to determine the reimbursement category. This information will be used to calculate your monthly reimbursement.

Mail all of these materials in the enclosed envelope to:

New York State Department of Health, Division of Nutrition
Child and Adult Care Food Program
150 Broadway, Floor 6 West
Albany, NY 12204-2719
Attention: Outreach Unit – New Center Application

Make certain that the original copy of all documents requiring signatures are sent, as copies cannot be accepted. If you have any questions, please feel free to contact a CACFP nutritionist at 1-800-942-3858, ext. 27103 or cacfp@health.state.ny.us.

Sincerely,

Lynne Oudekerk

Lynne Oudekerk
Assistant Director
Child and Adult Care Food Program

Enclosures

CACFP
Child and Adult Care Food Program
New York State Department of Health

APPLICATION FOR PARTICIPATION AND MANAGEMENT PLAN
for Sponsoring Organizations of Day Care Centers

CACFP Agreement Number: 5422

1.

Name of Sponsoring Organization	KEREN PEULOS		
Mailing Address	440 ALBANY AVENUE		
City	BROOKLYN	State	NY
Zip	11213	County	BROOKLYN / KINGS
Physical Location (if different than mailing address)			
Phone Number	(718) 483-9527		
Fax Number	(718) 483-9529		

2. Current Number of Centers: 2

3. Sponsor Type (Check One)

- ☐ For-Profit (Go to Question 4)
- ☑ Nonprofit (Indicate Sub-type Below)
  - ☐ Private – Nonprofit (Attach 501C3)
  - ☐ School Authority (Public or Private)
  - ☐ Government Entity
    Municipality Code: _____
  - ☐ Tribal (Attach copy of Tribal Letter)

4. Charity Registration Number

_____

☐ Not applicable, for-profit organization

5. Federal Employer Identification Number (FEIN)

113141647

6. List of the programs and services provided by your organization:

7. Has your organization participated in CACFP in the past seven years?

☐ Yes ☑ No

8. Name of the person we should call with questions about this application:

Name	Rabbi Zarchi		
Title	Administrator		
E-mail	CHEDERCHEL@GMAIL.COM		
Phone	(718) 483-9527	Ext.	

CACFP
Child and Adult Care Food Program
New York State Department of Health

APPLICATION FOR PARTICIPATION OF CHILD DAY CARE CENTERS
Serving Children 6 weeks to 12 years old

Instructions on back

ACFP Center Number	54220001
Name of Sponsoring Organization	KEREN PEULOS
Sponsor Phone #	(718) 483-9527
Center Name	CHEDER AT THE OHEL
Center Phone #	(718) 483-9527
Center Address	224 12 FRANCIS LEWIS BOULEVARD
City	CAMBRIA HEIGHTS
Zip	11411
County	BROOKLYN / KINGS

Federal Tax Status of Center (Check one)

- [ ] For-Profit
- [x] Nonprofit

Type of Center (Check one)

- [x] Child Care Center
- [ ] School Age Child Care
- [ ] Head Start
- [ ] Emergency Shelter

Age range of enrolled children: 6.0 YRS - 12.0 YRS

Type of Approval (Attach copy)

- [ ] Licensed/Registered
- [ ] License Exempt
- [ ] Military
- [ ] School

Participant Data

By visual appearance, using your best judgment, count the number of children in each category at this center and report these numbers below.

Racial/Ethnic Category	Number of Children	For State Use Only Census Data
Alaskan Native or American Indian		0.4%
Asian		7.5%
Black or African American		36.4%
Hispanic or Latino		19.8%
Native Hawaiian or other Pacific Islander		0.1%
White (not of Hispanic origin)		41.2%
Other		
Total		

Estimate the number of enrolled children in each of the reimbursement categories:

Free	Reduced	Paid	Total

8.

Hours open:	From 2:30 PM				To 5:30 PM		
Hours open on School Vacations & Weekends:	From				To		
Days open:	✓ Mon	✓ Tue	✓ Wed	✓ Thu	✓ Fri	Sat	Sun
Months open:	✓ Jan	✓ Feb	✓ Mar	✓ Apr	✓ May	✓ Jun	Jul	Aug	✓ Sep	✓ Oct	✓ Nov	✓ Dec

9. **What is the plan for meal preparation?** (Check all that apply)

- [x] A. Prepared at this center
- [ ] B. Prepared at Sponsor's central kitchen
- [ ] C. Purchased from a local school system
- [ ] D. Purchased from a food service company
- [ ] E. Purchased from a food service company as part of an umbrella contract
- [ ] F. Other _____

10. **Meal Service:**

	Meal Served	Usual Service: Number of Children Served	Usual Service: Time Meal Served	School Vacation/ Weekend Schedule: Time Meal Served
	Breakfast			
	AM Snack			
	Lunch			
✓	PM Snack			
✓	Supper			
	LN Snack			

11. What is the name of the elementary school children would attend if they lived next door to the center?

School Name & Address	

12. I certify this information is correct to the best of my knowledge.

Print name of person in charge of this center on a daily basis _____

Title _____

Signature _____

Date _____

CACFP
Child and Adult Care Food Program
New York State Department of Health

APPLICATION FOR PARTICIPATION OF CHILD DAY CARE CENTERS
Serving Children 6 weeks to 12 years old

Instructions on back

CACFP Center Number	54220002

1.

Name of Sponsoring Organization	KEREN PEULOS
Sponsor Phone #	(718) 483-9527
Center Name	KEREN PEULOS
Center Phone #	(718) 483-9527
Center Address	440 ALBANY AVENUE
City	BROOKLYN
Zip	11213
County	BROOKLYN / KINGS

2. **Federal Tax Status of Center** (Check one)
   - [ ] For-Profit
   - [x] Nonprofit

3. **Type of Center** (Check one)
   - [x] Child Care Center
   - [ ] School Age Child Care
   - [ ] Head Start
   - [ ] Emergency Shelter

4. **Age range of enrolled children:** 13.0 YRS - 15.0 YRS

5. **Type of Approval** (Attach copy)
   - [ ] Licensed/Registered
   - [ ] License Exempt
   - [ ] Military
   - [ ] School

6. **Participant Data**
   By visual appearance, using your best judgment, count the number of children in each category at this center and report these numbers below.

Racial/Ethnic Category	Number of Children	For State Use Only Census Data
Alaskan Native or American Indian		0.4%
Asian		7.5%
Black or African American		36.4%
Hispanic or Latino		19.8%
Native Hawaiian or other Pacific Islander		0.1%
White (not of Hispanic origin)		41.2%
Other		
Total		

7. Estimate the number of enrolled children in each of the reimbursement categories:

Free	Reduced	Paid	Total

8.

Hours open:	From 5:30 PM	To 9:00 PM
Hours open on School Vacations & Weekends:	From	To

Days open:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	✓	✓	✓	✓	✓		

Months open:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓

9. **What is the plan for meal preparation?** (Check all that apply)
   - [x] A. Prepared at this center
   - [ ] B. Prepared at Sponsor's central kitchen
   - [ ] C. Purchased from a local school system
   - [ ] D. Purchased from a food service company
   - [ ] E. Purchased from a food service company as part of an umbrella contract
   - [ ] F. Other _____

10. **Meal Service:**

	Meal Served	Usual Service: Number of Children Served	Usual Service: Time Meal Served	School Vacation/ Weekend Schedule: Time Meal Served
	Breakfast			
	AM Snack			
	Lunch			
✓	PM Snack			
✓	Supper			
	LN Snack			

11. What is the name of the elementary school children would attend if they lived next door to the center?

School Name & Address	

12. I certify this information is correct to the best of my knowledge.

Print name of person in charge of this center on a daily basis _____

Title _____

Signature _____

Date _____